

# SC Department of Disabilities and Special Needs COMMUNITY SERVICE STANDARDS

The mission of SCDDSN is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention. Consistent with the agency's mission, the intent of DDSN Community Service is to provide people with Mental Retardation/ Related Disability (MR/RD), Autism, and Head and Spinal Cord Injuries and Similar Disability (HASCI) the supports needed in order for them to meet their needs, pursue possibilities and achieve their life goals.

#### **DEFINITION**

Community Service is aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Community Service. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon.

#### ANTICIPATED OUTCOMES

Community Service provides individuals the opportunity to maximize their exposure, experience and participation within their local community. Through this process the individual will gain access to inclusive citizenship and social capital.

It is expected that SCDDSN Community Services be provided in a manner that promotes:

- Dignity and respect
- Health, safety and well-being
- Individual and family participation, choice control and responsibility
- Relationships with family and friends and community connections
- Personal growth and accomplishments.

It is also expected that Community Services reflect the principles of the agency and therefore services should:

- Be person centered
- Be responsive, efficient, and accountable
- Be strengths-based, results oriented
- Maximize potential
- Be based on best and promising practices

#### MINIMUM STANDARDS

#### General

Community Service will be provided in accordance with all state and federal laws.

Community Service will only be provided in or originate from facilities licensed by SCDDSN as Day Facilities.

Guidance: Please refer to SCDDSN Standards for Licensing Day Facilities for Children and Adults

Community Service will be provided in accordance with applicable SCDDSN Departmental Directives, procedures and guidance.

People receiving Community Service are free from abuse, neglect and exploitation.

People receiving Community Services are

- Informed of their rights
- Supported to learn about their rights
- Supported to exercise their rights

Guidance: Rights include: Human rights, Constitutional rights and Civil rights.

- Training includes responsibilities as well as rights
- Each person's right to privacy, dignity and confidentiality in all aspects of life is recognized, respected and promoted
- Personal freedoms are not restricted without due process
- People are expected to manage their own funds to the extent of their capability
- Due process is upheld, including the Human Rights Committee review of restriction of personal freedoms
- People with limited knowledge and experience receive training and opportunities to explore their individual rights and the responsibilities that accompany them

# Referral To Community Service

Community Service will only be provided to those who are authorized by a DSN Board or contracted Service Coordinator.

GUIDANCE: Service Coordination will provide the chosen Community Services provider with a referral notification that at a minimum includes the following information:

- Consumer information: (name, address, DOB, referral date, SS#, Medicaid # (when applicable), emergency contact information, and name of referring Service Coordinator)
- Authorization of service, number of authorized units
- Additional information: (Critical and emergency information, health/medical information, and care and supervision information

Individuals receiving Community Service are supported to make decisions and exercise choice regarding the specific Community Service they will receive.

Within 15 business days of receipt of a referral, the Community Service provider will notify the referring Service Coordinator in writing of their intent to:

- Accept the person for service, or
- Accept the referral for placement on the provider's waiting list, or
- Reject the referral

After acceptance into service but prior to providing Community Service, a preliminary plan must be developed that outlines the care, supervision and skills training/interventions to be provided.

GUIDANCE: Plan must include essential information to ensure appropriate services and supports are in place to assure health, safety, supervision and rights protection.

At the time of admission/entry into Community Service, the preliminary plan must be implemented.

GUIDANCE: Preliminary plan is to be implemented on the day of admission. When assessments are completed and training needs/priorities have been identified, the plan will be completed and will replace the preliminary plan.

# Assessment

Within thirty (30) calendar days of acceptance into Community Service and annually thereafter an assessment will be completed that identifies the abilities/strengths, interests/preferences and needs of the person in the following areas:

- Self-Advocacy/Self Determination
- Self-Esteem
- Coping Skills
- Personal Responsibility
- Personal Health and Hygiene
- Socialization
- Community Participation
- Mobility and Transportation
- Community Safety
- Money Management

Guidance: At a minimum, assessments must be completed every 12 months.

# The Plan

Based on the results of the assessment, within thirty (30) calendar days of admission and annually thereafter, a plan for Community Service is developed with participation from the individual and/or his/her legal guardian.

Guidance: At a minimum, the plan must be completed every 12 months.

# The plan must include:

 A description of the interventions to be provided including time limited and measurable goals/objectives.

GUIDANCE: The Community Service Plan is developed to identify: the community skills needed to enhance the person's opportunities within the community, necessary skills training in the areas of community awareness and community participation and develop real life skills through participation in a "natural setting".

Documentation of the description of how each intervention must be provided to indicate the data to be collected, and schedule for implementation.

- A description of the type and frequency of supervision to be provided.
- Emergency contact information.

GUIDANCE: All critical and emergency information for this individual must be documented in the plan.

• Current and comprehensive medical information.

GUIDANCE: Medications (all medications taken by the individual must be listed and any assistance of medicating must be documented (self medicate or assisted medicate). All relevant medication information must

be documented. All specific instructions concerning individual reactions, side effects or restrictions to medicine must be documented.

• Any information necessary to support the person in a Community Service setting.

The interventions in the plan must support the provision of Community Service as defined in these standards

### **Implementation**

As soon as the plan for Community Service is developed, it must be implemented.

Data must be collected as specified in the plan and must be sufficient to support the implementation of the plan for each unit of service reported.

GUIDANCE: Data must specify the amount of time the service was provided and must be sufficient to measure progress toward attainment of the goal or objective.

#### Data entries must be:

- True and accurate
- Complete
- Logically sequenced
- Typed or handwritten in permanent dark ink
- Dated and signed by the person making the entry

# **Monitoring**

At least monthly, the plan is monitored by the Program Director or his/her designee to determine its effectiveness.

The plan is amended when:

- No progress is being made on an intervention
- A new intervention, strategy, training, or support is identified, or
- The person is not satisfied with the intervention.